

HEALTH & WELFARE

C.L., "BUTCH" OTTER – Governor RICHARD M. ARMSTRONG – Director LESLIE M. CLEMENT - Administrator DIVISION OF MEDICAID Post Office Box 83720 Boise, Idaho 83720-0036 PHONE: (208) 334-6626 FAX: (208) 364-1888

February 14, 2008

Shannon Miller, Administrator Seasons at Boise-Seniorcare Turlock/Boise, LLC 10250 W Smoke Ranch Drive Boise, ID 83709

License #: RC-878

Dear Ms. Miller:

On January 18, 2008, a complaint investigation survey was conducted at Seasons at Boise-Seniorcare Turlock/Boise, LLC. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.
- Non-core issues, which are described on the Punch List, and for which you have submitted evidence of resolution.

This office is accepting your submitted plan of correction and evidence of resolution.

Should you have questions, please contact Debby Sholley, LSW, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

DEBBIE SHOLLEY, LSW

Team Leader

Health Facility Surveyor

Residential Community Care Program

DS/sc

C.L. "BUTCH" OTTER – Governor RICHARD M, ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator DIVISION OF MEDICAID Post Office Box 83720-Boise, Idaho 83720-0036 PHONE: (208) 334-6626 FAX: (208) 364-1888

January 30, 2008

CERTIFIED MAIL #: 7005 1160 0000 1506 7977

Shannon Miller, Administrator Seasons at Boise-Seniorcare Turlock/Boise, LLC 10250 West Smoke Ranch Drive Boise, ID 83709

Dear Ms. Miller:

Based on the complaint investigation survey conducted by our staff at Seasons at Boise-Seniorcare Turlock/Boise, LLC on **January 18**, **2008**, we have determined that the facility failed to protect residents from inadequate care. Based on interview and record review it was determined the facility retained a resident for whom the facility did not have the capability, capacity, and services to provide appropriate care. This resulted in inadequate care for 1 of 1 residents reviewed (#1).

This core issue deficiency substantially limits the capacity of Seasons at Boise-Seniorcare Turlock/Boise, LLC to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by March 3, 2008. We urge you to begin correction immediately.

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?
- How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- What date will the corrective action(s) be completed by?

Shannon Miller, Administrator January 30, 2008 Page 2 of 2

Return the **signed** and **dated** Plan of Correction to us by **February 12, 2008**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Chief of the Bureau of Facility Standards for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (February 12, 2008). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for the Bureau of Facility Standards to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after February 12, 2008, your request will not be granted.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying proof of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by February 18, 2008.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Seasons at Boise-Seniorcare Turlock/Boise, LLC.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP

Supervisor

Residential Community Care Program

JS/sc

Enclosure

c: Lynne Denne, Program Manager, Regional Medicaid Services, Region IV - DHW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
13R878		13R878		B. WING		C 01/18/2008	
			STREET AD	I DRESS, CITY, .	STATE, ZIP CODE	1 01/18	3/2008
			SMOKE RAI 83709	NCH DRIVE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
R 000	Initial Comments The following deficiency was cited during the		R 000				
	complaint investiga residential care/ass	tion survey conducte sisted living facility. The ng your complaint su	d at your he				
	Rachel Corey R.N. Team Coordinator Health Facility Surv	•					
	Debbie Sholley L.S. Health Facility Surv						
	CA = Cancer Da = Daughter ER = Emergency R LPN = Licensed Promotion MD = Medical Doctor NSA = Negotiated S NOC = Nighttime Res = Resident	actical Nurse or					TO MORPHUM PROPERTY AND ADMINISTRATION OF THE PROPE
R 008	16.03.22.520 Prote Care.	ct Residents from Inc	adequate	R 008			
	procedures are imp	nust assure that polic plemented to assure to rom inadequate care.	hat all			TO THE PARTY OF TH	
	determined the faci whom the facility did capacity, and servic care. This resulted	et as evidenced by: , and record review it lity retained a resider d not have the capab ces to provide approp in inadequate care fo Resident #1). The fin	nt for ility, oriate or 1 of 1				
Bureau of Fa	cility Standards						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

ZOY211

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUI 13R878		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			B. WING		C 01/18/2008			
NAME OF PROVIDER OR SUPPLIER STREET ADD			DRESS, CITY,	STATE, ZIP CODE		10/2000		
			10250 W : BOISE, ID	SMOKE RAI 83709	NCH DRIVE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE		
R 008	Continued From pa	age 1		R 008				
	Resident #1 was admitted to the facility on 2/27/07 with diagnosis that included Type II Diabetes, prostate cancer, hypertension and depression.							
	required moderate frequent falls due to required stand by a walker. Further, state of the resident's who unstable ambulation Additionally, the NS checks throughout	ated 7/18/07, documented the resident oderate assistance with transfers, had lest due to increased weakness and and by assistance when using his other, staff were to encourage the use ent's wheelchair due to the resident's abulation and frequent falls. The NSA instructed staff to do hourly ughout the night because of the increased risk for falls.						
· ·	Resident #1's record contained a Fax Cover Sheet dated 7/9/07 from the facility's LPN to the resident's physician and documented the following:				·			
	Out of 6 falls, 4 resadmission to hospicares. Refuses physpeak with a social Name) has started unable to be redirereports due to the cares (Resident's Name) care at assisted livorder for skilled nu Cover Sheet furthefalls occurred on; 67/2/07, and 7/7/07.	s dated 7/5/07 documented,						
	"Received several observation reports from 7/4/07. Resident is having hallucinations Resident states a man was in his room draining			-				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED		
13R878				01/1	01/18/2008		
NAME OF F	ROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
SEASON	IS AT BOISE-SENIOR	CARE TURLOCK	10250 W S BOISE, ID	SMOKE RAI 83709	NCH DRIVE		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACTIO	OVIDER'S PLAN OF CORRECTION I CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)	
R 008	Continued From pa	age 2		R 008			
	the blood out of him and blood was all over the floor. Yesterday evening res came out of his room naked was redirected back to his room and assisted with redressing. Second incident of res coming out naked and threatening to kill somebody. 911 was called Staff instructed to monitor resident closely throughout night."						
	A Progress Note da "received order from nursing."	ated 7/10/07 docume m MD to send res to	ented, skilled				
	On 7/11/07 a Progress Note documented, "Spoke with da (daughter) informed of physician order for skilled nursing home."						
t	Further review of the Progress Notes and Incident/Occurrence Reports for Resident #1 documented the resident had the following falls:						
!	7/16/07 the residen resident refused to 7/19/07 fall with no		ury and				
	"Meeting with da th confusion. Da infor- level of care and in need to be tried. Inf	ated 7/23/07 documents am regarding frequent that resident is formed of interventions include hand a Noc time sitte	falls and exceeding ons that ospice,				
	A document titled Doctor Office Visit dated 7/26/07, documented, "(Resident's Name) has experienced 12 falls since 6/1/07, 5 falls resulting in ER visits for abd., back and left hip pain. Staff has noticed increase weakness in lower extremities. (Resident's Name) has also been having an increase in confusion and						

ZOY211

T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NU				COMPL	ETED	
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hallucinations. He is May we PLEASE is (Resident's Name) regarding providing is when the majorit. The resident's recovered for hospice is documentation reversion order for hospice is documentation reversion. Further review of the 1, documented the 15/07, 8/17/07, 2 A Progress Note documented report in the ground on the is had been outside for time. Last check or found outside at 2: documented Residus ecure facility on 9. On 1/18/08 at 10:0 resident was always chair and in his roow wanted to keep the though he needed caregiver also states in many falls the fareports on all of the On 1/18/08 at 1:20 told staff not to fill of there were incident out." On 1/18/08 at 1:0 stated a couple of stated a couple of the stated and the stated	nas had a significant have a hospice order? We have also spol a private sitter at not y of his falls happen and contained a physervices dated 7/26/0 ealed hospice was in the Progress Note for e resident fell on 8/1 falls on 8/18/07 and ated 9/10/07, document res was found outside of the building. For undetermined among res was at 1:45 a.m. 40 a.m." The Progreent #1 was transferr /12/07. 6 a.m., a caregiver set is falling out of bed, on the stated the factor in the facility more supervision. The decause the resident at the facility did not fill out in the factor incident reports be the set incident reports be the set incident reports were months ago there was months ago there was months ago there was set in the set incident reports were months ago there was months ago there was monther care months ago there was monther care monther ago there was monther ago there was monther care monther ago the monther care monther ago the monther care mon	r for ke with da be as that " " ician's ". Further nitiated on Resident 1/07, 18/20/07. Justide on Resident ount of n. res so Note led to a stated the pout of his amily eity even he dent had neident d, "I never put I know le not filled giver les an less that with the less that had neident less an less an less an less that with the less that had neident less an less an less that had neident less an less that had neident less that had neide	R 008				
	ROVIDER OR SUPPLIER S AT BOISE-SENIOR SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From path allucinations. He is May we PLEASE is (Resident's Name) regarding providing is when the majorit. The resident's recoorder for hospice is documentation revolved for the properties of the ground on the interest of the ground in his root wanted to keep the though he needed caregiver also states in the ground of the ground	The resident's record contained a physorder for hospice services dated 7/26/0 documentation revealed hospice was in 7/30/07. Further review of the Progress Note for #1, documented the resident fell on 8/1 8/15/07, 8/17/07, 2 falls on 8/18/07 and A Progress Note dated 9/10/07, documented the resident fell on 8/1 8/15/07, 8/17/07, 2 falls on 8/18/07 and A Progress Note dated 9/10/07, documented the resident fell on 8/1 8/15/07, 8/17/07, 2 falls on 8/18/07 and A Progress Note dated 9/10/07, documented the resident fell on 8/1 8/15/07, 8/17/07, 2 falls on 8/18/07 and A Progress Note dated 9/10/07, documented the resident fell on 8/1 8/15/07, 8/17/07, 2 falls on 8/18/07 and A Progress Note dated 9/10/07, documented the ground on the side of the building. I had been outside for undetermined am time. Last check on res was at 1:45 a.r found outside at 2:40 a.m." The Progred documented Resident #1 was transferr secure facility on 9/12/07. On 1/18/08 at 10:06 a.m., a caregiver secure facility on 9/12/07. On 1/18/08 at 10:06 a.m., a caregiver secure facility on 9/12/07. On 1/18/08 at 1:20 p.m., the LPN stated to keep the resident at the facility did not fill out i reports on all of them. On 1/18/08 at 1:20 p.m., the LPN stated told staff not to fill out incident reports be the ware were incidents where reports were out." On 1/18/08 at 1:20 p.m., the LPN stated told staff not to fill out incident reports be the ware were incidents where reports were out." On 1/18/08 at 1:20 p.m., the LPN stated told staff not to fill out incident reports be the reward and the facility of the f	The resident's record contained a physician's order for hospice services dated 7/26/07. Further documentation revealed hospice was initiated on 7/30/07. Further review of the Progress Note for Resident #1, documented the resident fell on 8/11/07, A Progress Note dated 9/10/07, documented, "received report that res was found outside on the ground on the side of the building. Resident was always falling out of bed, out of his chair and in his room. She stated the family wanted to keep the resident at the facility even though he needed more supervision. The caregiver also stated because the resident had so many falls the facility did not fill out incident reports were not filled where were incidents where reports were not filled where were incidents where reports were not filled	ROVIDER OR SUPPLIER 13R878 ROVIDER OR SUPPLIER S AT BOISE-SENIORCARE TURLOCK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 hallucinations. He has had a significant decline. May we PLEASE have a hospice order for (Resident's Name)? We have also spoke with da regarding providing a private sitter at noc as that is when the majority of his falls happen." The resident's record contained a physician's order for hospice services dated 7/26/07. Further documentation revealed hospice was initiated on 7/30/07. 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On 1/18/08 at 1:20 p.m., the LPN stated, "I never told staff not to fill out incident reports but I know there were incidents where reports were not filled out." On 1/18/08 at 11:05 a.m., another caregiver stated a couple of months ago there was an	A BUILDING B. WING 13R878 ROVIDER OR SUPPLIER S AT BOISE-SENIORCARE TURLOCK SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 R 008 R	SCORRECTION TO DENTIFICATION NUMBER: 13R878 ROVIDER OR SUPPLIER S AT BOISE-SENIORCARE TURLOCK STREET ADDRESS, CITY, STATE, ZIP CODE 10250 W SMOKE RANCH DRIVE BOISE, ID 83709 PROVIDERS PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTEYING INFORMATION) Continued From page 3 hallucinations. He has had a significant decline. May we PLEASE: have a hospice order for (Resident's Name)? 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The caregiver also stated because the resident had so many fails the facility did not fill out incident reports but I know there were incidents where reports were not filled out." On 1/18/08 at 11:05 a.m., another caregiver stated a couple of months ago there was an	

AND PLAN OF CORRECTION IDENTIFICA"		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C 01/18/2008	
			DRESS, CITY, S	TATE, ZIP CODE	01/3	0,2000	
l l			SMOKE RAN				
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R 008	Continued From pa	age 4		R 008			
	in his shower room. The resident had placed towels over the shower drain to plug it up and water was running onto the floor. On 1/18/08 at 11:35 a.m., another caregiver						
	stated, "The last fe	ew months of his life l Maybe 3 to 4 times a	he was				
	she informed the r to transfer the resi the family became was agreed the fac the family provided	p.m., the LPN stated esident's family about dent to a skilled nurs "really" upset. There cility would retain the d a night time sitter. It provide the sitter as a	It the need ing facility fore, it resident if lowever,		\$ •	,	
	they determined the needs. The facility continued to fall ar resulting in injuries Additionally, it was not only a danger	d Resident #1 for 66 ney could not meet hi retained Resident #7 nd fell with greater fres and several ER visit documented the resto himself but also ot equent hallucinations uate care.	s safety I when he equency ts. ident was her				



HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator DIVISION OF MEDICAID Post Office Box 83720 Boise, Idaho 83720-0036 PHONE: (208) 334-6626 FAX: (208) 364-1888

January 30, 2008

Shannon Miller, Administrator Seasons at Boise-Seniorcare Turlock/Boise, LLC 10250 West Smoke Ranch Drive Boise, ID 83709

Dear Ms. Miller:

On January 18, 2008, a complaint investigation survey was conducted at Seasons at Boise-Seniorcare Turlock/Boise, LLC. The survey was conducted by Rachel Corey, RN and Debra Sholley, LSW. This report outlines the findings of our investigation.

Complaint # ID00003370

Allegation #1:

The facility did not fill out incident reports each time an identified resident fell.

Findings:

Based on interview and record review, it was determined a facility did not fill out incident reports each time an identified resident fell.

On January 18, 2008 between 8:00 a.m. and 3:00 p.m., Eight staff members were interviewed. Four out of Eight staff members confirmed incident reports were not always completed each time the identified resident fell.

On January 18, 2008 at 2:20 p.m., the facility licensed practical nurse stated, "I never told staff not to fill incident reports out, but I know there are incidents where reports did not get filled out."

Conclusion:

Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.350.01 for not notifying the administrator of all incidents regarding an identified resided. The facility was required to submit evidence of resolution within 30 days. Additionally, the facility was cited a core deficiency at 16.03.33.520 for maintaining a resident above level of care. The facility was required to submit a plan of correction.

Shannon Miller, Administrator January 30, 2008 Page 2 of 2

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

DEBBIE SHOLLEY, LSW Team Leader Health Facility Surveyor Residential Community Care Program

DS/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program Debra Sholley, LSW, Health Facility Surveyor



BUREAU OF FACILITY STANDARDS P.O. Box 83720 Boise, ID 83720-0036 (208) 334-6626 fax: (208) 364-1888 201

ASSISTED LIVING Non-Core Issues Punch List

Soull's Name		
Facility Name Seasons a Boise	Physical Address 10250 W. Smuke 19	Phone Number 208-322-2900
Administrator Shannun Miller	City	ZIP Code
Survey Team Leader		Survey Date
Deboie Sholley	Survey_Type	Survey Date
NON-CORE ISSUES /		1/10/50
ITEM RULE#	DESCRIPTION	
# 16.03.22	DESCRIPTION	DATE BFS RESOLVED USE
1 350.0 The adm	inistrato Las not notified	of all accidents
and incluen	inistrato Las not notified it	
2 350.01 the ardmi	report after each accident	investigation
and türitten	re post after each acculent	d lacidost
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Response Required Date Signature of Facility Repres	entative COC	Date Şigned
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